		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0033803

Facility Name: Anchorage of Beecher

Address: 1201 Dixie Highway (Number) Beecher (City) 60401 (Zip Code)

County: Will

Telephone Number: 708-946-2600 **Fax #** 708-946-9411

IDPA ID Number: 36-2166970-002

Date of Initial License for Current Owners: 09/12/1988

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code	501(c)3	[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Donald H. Primdahl **Telephone Number:** 630-521-8034

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2003 to 06/30/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Thomas L. Noesen, Jr.
(Title) Treasurer

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Anchorage of Beecher # 0033803 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	96	Skilled (SNF)	96	35,136	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	96	TOTALS	96	35,136	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	18,080	9,634	3,033	30,747	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,080	9,634	3,033	30,747	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.51%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Meals on Wheels, Staff Food Services

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 09/12/1988

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date _____ NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 14 and days of care provided 3,033

Medicare Intermediary Adminastar Federal, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/2004 Fiscal Year: 06/30/2004

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Anchorage of Beecher # 0033803 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	205,822	18,249	7,575	231,646		231,646		231,646			1
2	Food Purchase		187,323		187,323	(7,163)	180,160	(12,231)	167,929			2
3	Housekeeping	109,290	21,431		130,721		130,721		130,721			3
4	Laundry			85,081	85,081		85,081		85,081			4
5	Heat and Other Utilities			68,960	68,960		68,960		68,960			5
6	Maintenance	68,379	12,034	32,294	112,707		112,707		112,707			6
7	Other (specify):*											7
8	**TOTAL General Services**	383,491	239,037	193,910	816,438	(7,163)	809,275	(12,231)	797,044			8
	B. Health Care and Programs											
9	Medical Director			13,800	13,800		13,800		13,800			9
10	Nursing and Medical Records	1,678,945	379,540	40,991	2,099,476	(88,370)	2,011,106		2,011,106			10
10a	Therapy	93,106	2,623	267,853	363,582		363,582		363,582			10a
11	Activities	69,661	1,157	11,303	82,121	8,333	90,454		90,454			11
12	Social Services	43,367		869	44,236		44,236		44,236			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,885,079	383,320	334,816	2,603,215	(80,037)	2,523,178		2,523,178			16
	C. General Administration											
17	Administrative	81,669			81,669	111,621	193,290		193,290			17
18	Directors Fees											18
19	Professional Services			460,272	460,272	(155,311)	304,961	(238,144)	66,817			19
20	Dues, Fees, Subscriptions & Promotions			16,302	16,302	538	16,840	(3,319)	13,521			20
21	Clerical & General Office Expenses	155,763	14,746	112,624	283,133	7,464	290,597	(74,085)	216,512			21
22	Employee Benefits & Payroll Taxes			673,468	673,468	24,884	698,352		698,352			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,744	3,744	557	4,301		4,301			24
25	Other Admin. Staff Transportation			1,156	1,156	3,688	4,844		4,844			25
26	Insurance-Prop.Liab.Malpractice			75,791	75,791		75,791		75,791			26
27	Other (specify):*											27
28	**TOTAL General Administration**	237,432	14,746	1,343,357	1,595,535	(6,559)	1,588,976	(315,548)	1,273,428			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,506,002	637,103	1,872,083	5,015,188	(93,759)	4,921,429	(327,779)	4,593,650			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Anchorage of Beecher #0033803 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			29,519	29,519		29,519	60,839	90,358			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			170,621	170,621		170,621	(16,062)	154,559			32
33	Real Estate Taxes			2,727	2,727		2,727	(2,727)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			15,416	15,416	(15,416)						35
36	Other (specify):*											36
37	**TOTAL Ownership**			218,283	218,283	(15,416)	202,867	42,050	244,917			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			7,515	7,515	102,012	109,527		109,527			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops					7,163	7,163		7,163			41
42	Provider Participation Fee			52,704	52,704		52,704		52,704			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			60,219	60,219	109,175	169,394		169,394			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,506,002	637,103	2,150,585	5,293,690		5,293,690	(285,729)	5,007,961			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Anchorage of Beecher # 0033803 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(12,231)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	60,839	30		9
10	Interest and Other Investment Income	(329)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(15,733)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(74,085)	21		24
25	Fund Raising, Advertising and Promotional	(3,319)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Adjoining Property Tax	(2,727)	33		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (47,585)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule VIII-B	(223,927)	19	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (223,927)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (271,512)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops	X		7,163	2	40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs	X		102,012	10	43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$ 109,175		47

Anchorage of Beecher

ID# 0033803

Report Period Beginning: 07/01/2003

Ending: 06/30/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Anchorage of Beecher # 0033803 **Report Period Beginning:** 07/01/2003 **Ending:** 06/30/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(12,231)	0	0	0	0	0	0	0	0	0	0	(12,231)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(12,231)	0	0	0	0	0	0	0	0	0	0	(12,231)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(223,927)	(14,217)	0	0	0	0	0	0	0	0	0	(238,144)	19
20	Fees, Subscriptions & Promotions	(3,319)	0	0	0	0	0	0	0	0	0	0	(3,319)	20
21	Clerical & General Office Expenses	(74,085)	0	0	0	0	0	0	0	0	0	0	(74,085)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(301,331)	(14,217)	0	0	0	0	0	0	0	0	0	(315,548)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(313,562)	(14,217)	0	0	0	0	0	0	0	0	0	(327,779)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Anchorage of Beecher **#** 0033803 **Report Period Beginning:** 07/01/2003 **Ending:** 06/30/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	60,839	0	0	0	0	0	0	0	0	0	0	60,839	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(16,062)	0	0	0	0	0	0	0	0	0	0	(16,062)	32
33	Real Estate Taxes	(2,727)	0	0	0	0	0	0	0	0	0	0	(2,727)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	42,050	0	0	0	0	0	0	0	0	0	0	42,050	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(271,512)	(14,217)	0	0	0	0	0	0	0	0	0	(285,729)	45

Facility Name & ID Number Anchorage of Beecher # 0033803 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Bensenville Home Society	100	Anchorage of Bensenville	Bensenville	Lifelink Area Housing	Various	Independent Living
Lifelink Corporation (BHS Parent)	100	Pine Acres care Center	DeKalb	Bridgeway of Bensenville	Bensenville	Independent Living
				Lifelink Charities	Bensenville	Fund Raising
				Lifelink Services	Bensenville	Proj. Devel.
				See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Management Fees	$ 35,525	Lifelink Corporation (V.P. Health Care)	100.00%	$ 21,613	$ (13,912)	1
2	V	19	Management Fees	10,142	Lifelink Corporation (Pastoral Care)	100.00%	9,837	(305)	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 45,667			$ 31,450	$ * (14,217)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Anchorage of Beecher # 0033803 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2	NO COMPENSATION IS PAID TO ANY OWNERS, RELATIVES OR BOARD MEMBERS										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Anchorage of Beecher # 0033803 Report Period Beginning: 07/01/2003 Ending: 6/30/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: LIFELINK CORPORATION
Street Address: 331 S. YORK ROAD
City / State / Zip Code: BENSENVILLE, IL. 60106
Phone Number: (630) 521-8034
Fax Number: (630) 521-8067

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATION	DIRECT PROG. COST	64,735,304	12	$ 1,172,189	$ 1,172,189	5,293,690	$ 95,855	1
2	19	PROFESSIONAL SERVICES	DIRECT PROG. COST	64,735,304	12	276,186		5,293,690	22,585	2
3	20	FEES, SUBSCRIPTIONS, PROM	DIRECT PROG. COST	64,735,304	12	5,447		5,293,690	445	3
4	21	GEN. OFFICE EXPENSE	DIRECT PROG. COST	64,735,304	12	59,494		5,293,690	4,865	4
5	22	EMP. TAXES & BENEFITS	DIRECT PROG. COST	64,735,304	12	243,432		5,293,690	19,907	5
6	24	TRAVEL & SEMINARS	DIRECT PROG. COST	64,735,304	12	6,528		5,293,690	534	6
7	25	OTHER STAFF TRANS.	DIRECT PROG. COST	64,735,304	12	27,275		5,293,690	2,230	7
8	35	RENTAL EQUIPMENT	DIRECT PROG. COST	64,735,304	12	836		5,293,690	68	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,791,387	$ 1,172,189		$ 146,489	25

Facility Name & ID Number Anchorage of Beecher # 0033803 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1			X	REFINANCE MORTGAGE	***	***	$ ***	$ ***	***	***	$ 154,888	1
2				AND CAPITAL PROJECTS								2
3												3
4				*** SEE ATTACHED								4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 154,888	9
	B. Non-Facility Related*											
10	IDPA Repayment Plan										15,733	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 15,733	14
15	TOTALS (line 9+line14)						$	$			$ 170,621	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 0 Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Anchorage of Beecher # 0033803 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 0	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 0	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 0	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$ 0	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$ 0	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 0	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	0	8
	2000	0	9
	2001	0	10
	2002	0	11
	2003	0	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible] Office of Health Finance at (217) 782-1600.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Anchorage of Beeche COUNTY Will

FACILITY IDPH LICENSE NUMBER 0033803

CONTACT PERSON REGARDING THIS REPORT Donald H. Primdahl

TELEPHONE 630-521-8034 FAX #: 630-521-8067

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

Facility Name & ID Number Anchorage of Beecher # 0033803 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,095 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 121,720 2. Number of Years Over Which it is Being Amortized: 40

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	LONG TERM CARE	123,116	1988	$ 246,000	1
2					2
3	TOTALS	123,116		$ 246,000	3

Facility Name & ID Number Anchorage of Beecher # 0033803 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	96		1988	1985	$ 2,456,000	$ 37,785	40	$ 61,400	$ 23,615	$ 939,420	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1985 ADMIN. BLDG. RENOVATION			1985	141,912	3,548	40	3,548		92,569	9
10	1986 ADMIN. BLDG. RENOVATION			1986	10,935	273	40	273		6,703	10
11	LAND IMPROVEMENTS (CURBS, LIGHTS, ETC.)			1988	160,000		10			160,000	11
12	WATER CONDITIONER			1988	5,417		20	217	217	4,337	12
13	SIGN RENOVATION			1988	2,490		20	125	125	2,125	13
14	INSTALLATION OF VERTICAL BLINDS			1998	1,582		20	79	79	1,422	14
15	INSTALLATION OF TIME CLOCK			1988	8,273		20	414	414	7,037	15
16	LAND IMPROVEMENTS			1990	5,035		20	252	252	3,779	16
17	COOLED CONDENSERS AND COMPRESSORS			1990	3,782		20	189	189	2,552	17
18	ROOF REPAIRS			1990	15,370		10			15,370	18
19	(20) RADIATOR VALVES			1991	7,200		20	360	360	5,181	19
20	TOILET FRAMES AND OTHER EQUIP.			1991	2,114		20	106	106	1,526	20
21	RUBBER ROOF SYSTEM			1992	74,550		10			74,550	21
22	WALK AND PATIO CONSTRUCTION			1992	9,255		10			9,255	22
23	PATIO FENCE			1992	3,620		10			3,620	23
24	WIRE GLASS DOOR			1992	509		20	25	25	305	24
25	CUBICAL CURTINS AND TRACK			1992	5,762		20	288	288	3,513	25
26	(49) MIRRORS			1992	4,470		20	224	224	2,732	26
27	SMOKE DAMPERS, FIREWALL AND VENT. RENOV.			1993	1,174		20	59	59	604	27
28	DUMPSTER PAD			1993	2,450	20	20	122	102	1,249	28
29	WANDER SAF-T-LOCK ALARM SYSTEM			1993	16,030	534	20	802	268	8,208	29
30	SKILLED WING DINNING ROOM RENOVATION			1993	2,900	72	20	145	73	1,485	30
31	ISE GARBAGE DISPOSAL			1993	603		20	30	30	312	31
32	KITCHEN COUNTER AND FIRE DOOR			1994	1,945	128	10	128		1,945	32
33	DINNING ROOM CARPETING			1994	7,832	719	10	719		7,832	33
34	BOILER			1997	3,016	302	10	302		1,986	34
35	3" BACKFLOW PREVENTOR			1999	4,935	493	10	493		2,508	35
36	CARPETING			1999	20,943	2,094	10	2,094		11,170	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Anchorage of Beecher # 0033803 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	BOOSTER HEATER	1999	$ 977	$ 98	10	$ 98	$	$ 473	37
38	20" MARATON 1200 EXTRACTOR	2001	1,673	167	10	167		571	38
39	WATER SOFTNER	2001	5,700	570	10	570		1,853	39
40	ASPHAL REMOVAL AND REPLACEMENT	2001	22,094	2,210	10	2,210		6,445	40
41	REPAIR AND REPLACE DAMAGED SHOWER STALLS	2002	32,044	3,204	10	3,204		8,119	41
42	REPAIR AND REPLACE DAMAGED SHOWER STALLS	2002	6,400	640	10	640		1,067	42
43	REPAIR FLOOR IN DINING ROOM	2002	12,639	1,264	10	1,264		2,633	43
44	REPAIR AND REPLACE DAMAGED SHOWER STALLS	2003	6,400	640	10	640		960	44
45	OTHER ASSETS & IMPAIRMENTS NOT ALLOWED			(34,413)			34,413		45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,068,031	$ 20,348		$ 81,187	$ 60,839	$ 1,395,416	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Anchorage of Beecher # 0033803 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 48,394	$ 8,326	$ 8,326	$	5 TO 10	$ 30,033	71
72	Current Year Purchases	997	150	150		5 TO 10	150	72
73	Fully Depreciated Assets	415,374				5 TO 10	415,374	73
74								74
75	TOTALS	$ 464,765	$ 8,476	$ 8,476	$		$ 445,557	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RESIDENT OUTINGS	1985 FORD BUS	1997	$ 10,000	$ 695	$ 695	$	6	$ 10,000	76
77										77
78										78
79										79
80	TOTALS			$ 10,000	$ 695	$ 695	$		$ 10,000	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,788,796	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 29,519	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 90,358	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 60,839	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,850,973	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Anchorage of Beecher # 0033803 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO

16. Rental Amount for movable equipment: $ 15,416 Description: See Attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Anchorage of Beecher # 0033803 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Anchorage of Beecher # 0033803 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or)	Total Units	Total Cost	
			Units of Service	Cost	Units	Cost	Allocated)	(Column 2 + 4)	(Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	hrs	$		$ 26,406	$ 751		$ 27,157	1
2	Licensed Speech and Language Development Therapist	10a	hrs			11,134	571		11,705	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	hrs			25,969	1,301		27,270	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Medicare Therapy	10a				203,983			203,983	13
14	TOTAL			$		$ 267,492	$ 2,623		$ 270,115	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Anchorage of Beecher # 0033803 **Report Period Beginning:** 07/01/2003 **Ending:** 06/30/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 23,885	$ 304,458	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 103,297)	186,244	1,280,526	3
4	Supply Inventory (priced at COST)	9,920	54,547	4
5	Short-Term Investments		114,417	5
6	Prepaid Insurance	32,371	233,059	6
7	Other Prepaid Expenses	2,748	70,469	7
8	Accounts Receivable (owners or related parties)		14,687,051	8
9	Other(specify):		757,867	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 255,168	$ 17,502,394	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		921,501	13
14	Buildings, at Historical Cost		22,749,670	14
15	Leasehold Improvements, at Historical Cost		702,333	15
16	Equipment, at Historical Cost		5,609,195	16
17	Accumulated Depreciation (book methods)		(22,708,371)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached		5,279,855	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$ 12,554,183	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 255,168	$ 30,056,577	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 70,203	$ 1,934,043	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,139	210,529	28
29	Short-Term Notes Payable	311,662	15,031,783	29
30	Accrued Salaries Payable	132,757	830,618	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,374	18,132	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Affiliates	2,350,102	28,528,412	36
37	Deferred Revenue	35,355	311,790	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,926,592	$ 46,865,307	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,926,592	$ 46,865,307	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,671,424)	$ (16,808,730)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 255,168	$ 30,056,577	48

***(See instructions.)**

Facility Name & ID Number Anchorage of Beecher # 0033803 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (772,994)	1
2	Restatements (describe):		2
3	**Impairment of Assets**	(1,409,648)	3
4	**Other Audit Adjustment**	(1,893)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,184,535)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(491,401)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Restricted Contributions**	4,512	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (486,889)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,671,424)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Anchorage of Beecher # 0033803 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,054,185	1
2	Discounts and Allowances for all Levels	(2,267,748)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,786,437	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	971,812	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 971,812	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	7,163	12
13	Barber and Beauty Care	10,267	13
14	Non-Patient Meals	12,231	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	5,900	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 35,561	23
	D. Non-Operating Revenue		
24	Contributions	8,150	24
25	Interest and Other Investment Income***	329	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,479	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,802,289	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	816,438	31
32	Health Care	2,603,215	32
33	General Administration	1,595,535	33
	B. Capital Expense		
34	Ownership	218,283	34
	C. Ancillary Expense		
35	Special Cost Centers	7,515	35
36	Provider Participation Fee	52,704	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,293,690	40
41	**Income before Income Taxes (line 30 minus line 40)****	(491,401)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (491,401)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Anchorage of Beecher # 0033803 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,036	2,135	$ 64,539	$ 30.23	1
2	Assistant Director of Nursing					2
3	Registered Nurses	20,653	22,505	550,010	24.44	3
4	Licensed Practical Nurses	15,924	17,594	377,898	21.48	4
5	Nurse Aides & Orderlies	57,330	64,344	779,604	12.12	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,893	2,080	39,607	19.04	9
10	Activity Assistants	1,892	2,063	30,054	14.57	10
11	Social Service Workers	1,963	2,080	43,367	20.85	11
12	Dietician					12
13	Food Service Supervisor	1,832	2,080	43,066	20.70	13
14	Head Cook	1,472	1,966	24,830	12.63	14
15	Cook Helpers/Assistants	15,619	16,910	137,926	8.16	15
16	Dishwashers					16
17	Maintenance Workers	3,176	3,608	68,379	18.95	17
18	Housekeepers	9,130	10,176	109,290	10.74	18
19	Laundry					19
20	Administrator	2,032	2,080	81,669	39.26	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,896	2,080	33,774	16.24	23
24	Clerical	5,610	6,063	67,942	11.21	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,365	3,693	54,047	14.63	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	145,823	161,457	$ 2,506,002 *	$ 15.52	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	143	$ 6,380	1-3	35
36	Medical Director		13,800	9-3	36
37	Medical Records Consultant	24	1,050	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,117	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	12	684	11-3	44
45	Social Service Consultant	15	869	12-3	45
46	Other(specify)				46
47	Dental Consultant		3,516	39-3	47
48					48
49	TOTAL (lines 35 - 48)	194	$ 27,416		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	62	$ 3,206		50
51	Licensed Practical Nurses	391	15,285		51
52	Nurse Aides	793	17,234		52
53	TOTAL (lines 50 - 52)	1,246	$ 35,725		53

Facility Name & ID Number Anchorage of Beecher # 0033803 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Marsha Quale	Administrator	0	$ 81,669
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 81,669

B. Administrative - Other

Description	Amount
NONE	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Lifelink Corporation	Mgmt. Fee	$ 45,667
Lifelink Corporation	Data Processing	31,712
Lifelink Cor[. & BHS	Allocated M & G	370,416
Reingruber & Company	Medicare Consultant	4,211
Rever Health Care	A/R Consultant	8,266
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 460,272

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 90,633
Unemployment Compensation Insurance	5,910
FICA Taxes	181,184
Employee Health Insurance	340,801
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Ins / Disability Ins.	12,516
Pension (TSA)	27,446
Proffesional Societies/ Employee Relations	13,040
Staff Medical Exams	1,938
Allocation Schedule VII-B	4,977
Allocation Schedule VIII-B	19,907
TOTAL (agree to Schedule V, line 22, col.8)	$ 698,352

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
NONE		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	67
Health Care Worker Background Check	
(Indicate # of checks performed 21)	147
Subscriptions & Reference Publications	1,563
Association Dues	11,206
Public Relations	3,319
Allocation Schedule VII-B	93
Allocation Schedule VIII-B	445
Less: Public Relations Expense	(3,319)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,521

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,744
Allocation Schedule VII-B	23
Allocation Schedule VIII-B	534
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,301

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Anchorage of Beecher # 0033803 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2	NONE												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Anchorage of Beecher # 0033803 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **LSN/AAHSA $4,274**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **5-10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **37,189** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **52,704**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **NO** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **KPMG** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **NO** If no, please explain. **AUDIT HAS NOT BEEN ISSUED**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

BENSENVILLE HOME SOCIETY

REPORTING PERIOD 07/01/03 - 06/30/04

IX INTEREST EXPENSE

FACILITY NUMBER NAME

0014258	ANCHORAGE OF BENSENVILLE
0033803	ANCHORAGE OF BEECHER
0005066	PEOTONE SENIOR LIVING CENTER
0039289	PINE ACRES CARE CENTER

THE BENSENVILLE HOME SOCIETY (BHS) IN CONJUNCTION WITH ITS AFFILIATED CORPORATIONS, LIFELINK AND BRIDGEWAY OF BENSENVILLE, HAVE ISSUED 1989A, 1995A, AND 1998 BONDS THRU THE ILLINOIS HEALTH FACILITY AUTHORITY ON VARIOUS DATES. SEE COPY OF OFFICIAL STATEMENTS ATTACHED. THE 1989B AND 1995B BONDS WERE RETIRED WITH THE ISSUANCE OF THE 1998 BONDS.

INTEREST PAID AND ACCRUED

1989A SERIES	35,784
1995A SERIES	111,056
1998 SERIES	985,975

LETTER OF CREDIT AND OTHER FEES

1989A SERIES	56,514
1995A SERIES	136,210
1998 SERIES	5,389
TOTAL	1,330,928

INTEREST HAS BEEN ALLOCATED BASED ON THE USE OF THE BOND PROCEEDS.

ANCHORAGE OF BENSENVILLE	34.2% OF 1989 BONDS	31,562
	13.2% OF 1995 BONDS	32,615
	8.8% OF 1998 BONDS	87,474
	TOTAL	151,651
ANCHORAGE OF BEECHER	44.5% OF 1989 BONDS	41,074
	11.5% OF 1998 BONDS	113,814
	TOTAL	154,888
PINE ACRES CARE CENTER	30.3% OF 1995 BONDS	75,030
OTHER*		949,359
	TOTAL	1,330,928

* CORPORATE AND PARENT CORPORATE OFFICES AND NON-CARE RELATED.

XII B. # 16 EQUIPMENT RENTAL (PAGE14)

1. ADVACARE

GERI CHAIR	458.00	
PLEXUS 2200 RENTAL	1,464.00	
PLEXUS 2500 ULTRA AIR	510.00	
FLOWTRON LEG PUMP	1,896.00	
CPM MACHINE	2,517.00	
GENDRON BED FRAME	1,020.00	
BRODA CHAIR	560.00	
BRODA TRAY	54.00	
HI-BACK RECLINER	15.00	
		8,494.00

2. AMERICAN MEDICAL OXYGEN SALES

PORTABLE LIQUID QXYGEN		3,032.25

3. KCI THERAPUETICS

WOUND VAC RENTAL	1,430.00	
IRRADIATED VAC SMALL	247.91	
		1,677.91

4. GENESIS MEDICAL

BLUE SKY VERSATILE		437.50

5 PBCC

MAIL MACHINE		1,774.18
		15,415.84

DESCRIPTION OF LINE 24, SCHEDULE V:

NAME	JOB TITLE	DATE	LOCATION	SEM. TITLE	SPONSOR	COST
MARSHA QUALE	ADMINISTRATOR	11/16 - 11/18/03	ROSEMONT	2003 SENIOR HOUSING & ASSISTED LIVING	LSN	$771.00
PAT BAILEY	ACTIVITIES DIR.	10/22-10/24/03	DECATUR	I.A.P.A. CONVENTION	I.A.P.A.	$486.00
MARY ELLEN KOSKY	ASSIST. ACT. DIR.					
MARSHA QUALE	ADMINISTRATOR	3/31 - 4/2/04	CHICAGO	LSN CONFERENCE	LSN	$1,774.00
PAT RENZETTI	SOC. SERV. DIR.					
PAT BAILEY	ACTIVITIES DIR.					
JANICE BRAUN	FOOD SER. DIR.					
FRANCES GRAY	NURSING SUPERV.					
DONNA FOX	D.O.N.					
LAURA VELDHUIZEN	ASSIT. D.O.N.					

ALL OTHER SEMINARS LESS THAN $250.00:	$713.00
ALLOCATED COSTS - SCHEDULE VII B:	$23.00
ALLOCATED COSTS - SCHEDULE VIII B:	$534.00
SUB-TOTAL	$4,301.00
OUT OF STATE SEMINARS/CONFERENCES	-
TOTAL	$4,301.00

LIFELINK CORPORATION

BENSENVILLE HOME SOCIETY

ANCHORAGE OF BENSENVILLE	#	0014258
ANCHORAGE OF BEECHER	#	0033803
PINE ACRES CARE CENTER	#	0039289
PEOTONE SENIOR LIVING CENTER	#	0005066

SCHEDULE VII-A

ATTACHED ARE LISTS OF THE BOARD OF DIRECTORS FOR LIFELINK CORPORATION AND BENSENVILLE HOME SOCIETY.

NONE OF THESE DIRECTORS PROVIDE ANY SERVICES TO EITHER CORPORATION NOR DO THEY HAVE ANY OWNERSHIP IN ANY ENTITY THAT DOES BUSINESS WITH EITHER CORPORATION.

SCHEDULE VII-A3

NAME	CITY	TYPE OF BUSINESS
Hoyleton Youth and Family Services	Hoyleton	Social Services
Hoyleton Children's Home Foundation	Hoyleton	Fund Raising

BENSENVILLE HOME SOCIETY

REPORTING PERIOD 07/01/03 - 06/30/04

FACILITY NUMBER NAME

0033803 ANCHORAGE OF BEECHER

SCHEDULE XVII - LINE 41

	(1) BENSENVILLE HOME SOCIETY	(2) FACILITY	BHS RELATED (1) - (2)
ANCHORAGE OF BEECHER			
REVENUES	35,152,192	4,802,289	30,349,903
EXPENSES	37,526,218	5,293,690	32,232,528
NET INCOME (LOSS) FROM OPERATIONS	(2,374,026)	(491,401)	(1,882,625)

BENSENVILLE HOME SOCIETY
SCHEDUAL VII-B
6/30/2004

RECAP

LINE #	DESCRIPTION	0014258 ANCHORAGE OF BENSENVILLE	0033803 ANCHORAGE OF BEECHER	0039289 PINE ACRES CARE CENTER
2	FOOD PURCHASES	-	-	-
11	ACTIVITIES	32,638	8,333	3,472
17	ADMINISTRATIVE	21,022	15,766	15,766
19	PROFESSIONAL SERVICES	170	43	18
20	FEES, SUBSCRIPTIONS, PROM.	362	93	39
21	GENERAL OFFICE EXPENSE	1,365	757	677
22	EMPLOYMENT BENEFITS & TX.	8,315	4,977	4,598
24	TRAVEL AND SEMINARS	89	23	10
25	OTHER STAFF TRANSPORT.	3,386	1,458	1,133
34	RENT-FACILITIES & GROUND	-	-	-
35	RENTAL EQUIPMENT	-	-	-
	TOTAL	67,347	31,450	25,712

VICE PRESIDENT OF HEALTH CARE (020-050)

LINE #	DESCRIPTION	TOTAL	DIS-ALLOWED	ALLOWED	ANCHORAGE OF BENSENVILLE	ANCHORAGE OF BEECHER	PINE ACRES CARE CENTER
2	FOOD PURCHASES		-	-	-	-	-
11	ACTIVITIES	-	-	-	-	-	-
17	ADMINISTRATIVE	52,554	-	52,554	21,022	15,766	15,766
19	PROFESSIONAL SERVICES	24,183	24,183	-	-	-	-
20	FEES, SUBSCRIPTIONS, PROM.	12,599	12,599	-	-	-	-
21	GENERAL OFFICE EXPENSE	2,064	-	2,064	826	619	619
22	EMPLOYMENT BENEFITS & TX.	14,425		14,425	5,770	4,328	4,328
24	TRAVEL AND SEMINARS	-	-	-	-	-	-
25	OTHER STAFF TRANSPORT.	3,000	-	3,000	1,200	900	900
34	RENT-FACILITIES & GROUND	9,588	9,588	-	-	-	-
35	RENTAL EQUIPMENT	-	-	-	-	-	-
	TOTAL	118,413	46,370	72,043	28,817	21,613	21,613
	ALLOCATION %				40.0%	30.0%	30.0%

PASTORAL CARE(020-150)

LINE #	DESCRIPTION	TOTAL	DIS-ALLOWED	ALLOWED	ANCHORAGE OF BENSENVILLE	ANCHORAGE OF BEECHER	PINE ACRES CARE CENTER
2	FOOD PURCHASES	314	314	-	-	-	-
11	ACTIVITIES	69,442	-	69,442	32,638	8,333	3,472
17	ADMINISTRATIVE		-	-	-	-	-
19	PROFESSIONAL SERVICES	362	-	362	170	43	18
20	FEES, SUBSCRIPTIONS, PROM.	771	-	771	362	93	39
21	GENERAL OFFICE EXPENSE	1,148	-	1,148	540	138	57
22	EMPLOYMENT BENEFITS & TX.	5,414	-	5,414	2,545	650	271
24	TRAVEL AND SEMINARS	190	-	190	89	23	10
25	OTHER STAFF TRANSPORT.	4,652	-	4,652	2,186	558	233
34	RENT-FACILITIES & GROUND	2,112	2,112	-	-	-	-
35	RENTAL EQUIPMENT	115	115	-	-	-	-
	TOTAL	84,520	2,541	81,979	38,530	9,837	4,099
	ALLOCATION %				47.0%	12.0%	5.0%

FACILITY ID#: 0033803

FACILITY NAME: ANCHORAGE OF BEECHER
A FACILITY OF THE BENSENVILLE HOME SOCIETY

REPORT PERIOD: 07/01/03 - 06/30/04

SCHEDULE V

RECLASSIFICATIONS AND ADJUSTMENTS:

1.	LINE 21 CLERICAL & GENERAL	1,842	
	LINE 10 NURSING & RECORD KEEPING	13,642	
	LINE 35 RENT - EQUIPMENT		15,484
	TO RECLASSIFY RENTAL EQUIPMENT TO PROPER ACCOUNTS PER SCHEDULE XII B #16.		
2	LINE 11 ACTIVITIES	8,333	
	LINE 17 ADMINISTRATIVE	15,766	
	LINE 19 PROFESSIONAL SERVICES		31,407
	LINE 20 FEES, SUBSCRIPTIONS, PROM.	93	
	LINE 21 CLERICAL & GENERAL OFFICE	757	
	LINE 22 EMPLOYMENT BENEFITS & TAXES	4,977	
	LINE 24 TRAVEL & SEMINARS	23	
	LINE 25 OTHER STAFF TRANSPORTATION	1,458	
	TO RECLASSIFY MANAGEMENT FEES FROM PROFESSIONAL SERVICES TO PROPER ACCOUNTS.		
3	LINE 41 GIFT & COFFEE SHOP	7,163	
	LINE 2 FOOD PURCHASES		7,163
	TO RECLASSIFY COFFEE SHOP EXPENSES		
4	LINE 39 ANCILLARY SERVICE CENTER	102,012	
	LINE 10 NURSING & RECORD KEEPING		102,012
	TO RECLASSIFY PRIVATE PAY DRUGS TO SECTION D		
5.	LINE 17 ADMINISTRATIVE	95,855	
	LINE 19 PROFESSIONAL SERVICES		123,904
	LINE 20 FEES, SUBSCRIPTIONS, PROM.	445	
	LINE 21 CLERICAL & GENERAL OFFICE	4,865	
	LINE 22 EMPLOYMENT BENEFITS & TAXES	19,907	
	LINE 24 TRAVEL & SEMINARS	534	
	LINE 25 OTHER STAFF TRANSPORTATION	2,230	
	LINE 35 RENTAL EQUIPMENT	68	
	TO RECLASSIFY ALLOCATED MANAGEMENT AND GENERAL COSTS FROM PROFESSIONAL SERVICES TO PROPER ACCOUNTS.		

RECAP ABOVE ENTRIES

LINE 2 FOOD PURCHASES		7,163
LINE 10 NURSING & RECORD KEEPING		88,370
LINE 11 ACTIVITIES	8,333	
LINE 17 ADMINISTRATIVE	111,621	
LINE 19 PROFESSIONAL SERVICES		155,311
LINE 20 FEES, SUBSCRIPTIONS, PROM.	538	
LINE 21 CLERICAL & GENERAL OFFICE	7,464	
LINE 22 EMPLOYMENT BENEFITS & TAXES	24,884	
LINE 24 TRAVEL & SEMINARS	557	
LINE 25 OTHER STAFF TRANSPORTATION	3,688	
LINE 35 RENT - EQUIPMENT		15,416
LINE 39 ANCILLARY SERVICE CENTER	102,012	
LINE 41 GIFT & COFFEE SHOP	7,163	

BENSENVILLE HOME SOCIETY

REPORTING PERIOD 07/01/03 - 06/30/04

FACILITY NUMBER	NAME
0014258	ANCHORAGE OF BENSENVILLE
0033803	ANCHORAGE OF BEECHER
0039289	PINE ACRES CARE CENTER

SCHEDULE XV BALANCE SHEET (AFTER CONSOLIDATION)

LINE 23 - OTHER

BENEFICIAL INTEREST IN PERPETUAL TRUST	4,252,710
STUDENT LOANS RECEIVABLE	57,903
CASH RESTRICTED FOR STUDENT LOANS	33,524
DEFERRED COSTS AND OTHER INTANGIBLES, NET	708,204
OTHER ASSETS, NET	227,514
	5,279,855

BENSENVILLE HOME SOCIETY

SCHEDUAL XI - LINES 9 & 10

1985 / 1986 ALLOCATION OF RENOVATION COSTS FOR THE CFS BUILDING

	1985	1986
CONSTRUCTION COSTS:	1,735,410	133,721
CURRENT DEPRECIATION:	43,385	3,343

FACILITY FY 2002:	BENSENVILLE	BEECHER	PINE ACRES
FACILITY OPERATING EXP. (A)	11,662,930	5,293,690	4,695,279
TOTAL OPERATING EXP. (B)	64,735,304	64,735,304	64,735,304
(A) / (B)	18.02%	8.18%	7.25%

1985 COST PERCENTAGE	312,657	141,912	125,870
1985 DEPRECIATION PERCENT.	7,816	3,548	3,147
1986 COST PERCENTAGE	24,092	10,935	9,699
1986 DEPRECIATION PERCENT.	602	273	242

BENSENVILLE HOME SOCIETY
INDIRECT COSTS
SCHEDULE VIII-B
6/30/2004

RECAP

LINE #	DESCRIPTION	0014258 ANCHORAGE OF BENSENVILLE	0033803 ANCHORAGE BEECHER	0039289 PINE ACRES CARE CENTER
2	FOOD PURCHASES	-	-	-
17	ADMINISTRATIVE	211,186	95,855	85,019
19	PROFESSIONAL SERVICES	49,759	22,585	20,032
20	FEES, SUBSCRIPTIONS, PROM.	981	445	395
21	GENERAL OFFICE EXPENSE	10,719	4,865	4,315
22	EMPLOYMENT BENEFITS & TX.	43,858	19,907	17,656
24	TRAVEL AND SEMINARS	1,176	534	473
25	OTHER STAFF TRANSPORT.	4,914	2,230	1,978
26	INSURANCE	-	-	-
34	RENT-FACILITIES & GROUND	-	-	-
35	RENTAL EQUIPMENT	151	68	61
	TOTAL	322,742	146,490	129,930
	ALLOCATION	18.02%	8.18%	7.25%

		LIFELINK ADMINISTRATION (010)			LIFELINK BOARD & CORPORATE (020)		
LINE #	DESCRIPTION	TOTAL	DIS-ALLOWED	ALLOWED	TOTAL	DIS-ALLOWED	ALLOWED
2	FOOD PURCHASES	642	642	-	-	-	-
17	ADMINISTRATIVE	611,874	291,456	320,418	-	-	-
19	PROFESSIONAL SERVICES	147,729	147,635	94	9,845	-	9,845
20	FEES, SUBSCRIPTIONS, PROM.	1,760	187	1,573	-	-	-
21	GENERAL OFFICE EXPENSE	15,559	-	15,559	41	-	41
22	EMPLOYMENT BENEFITS & TX.	105,346	50,180	55,166	-	-	-
24	TRAVEL AND SEMINARS	14,183	7,655	6,528	-	-	-
25	OTHER STAFF TRANSPORT.	17,555	-	17,555	-	-	-
26	INSURANCE	-	-	-	2,222	2,222	-
34	RENT-FACILITIES & GROUND	32,064	32,064	-	-	-	-
35	RENTAL EQUIPMENT	476		476	-	-	-
	TOTAL	947,188	529,819	417,369	12,108	2,222	9,886

		LIFELINK BUSINESS OFFICE (030)			LIFELINK SUPPORT SERVICES (080)		
LINE #	DESCRIPTION	TOTAL	DIS-ALLOWED	ALLOWED	TOTAL	DIS-ALLOWED	ALLOWED
2	FOOD PURCHASES	133	133	-	-	-	-
17	ADMINISTRATIVE	594,408	46,577	547,831	154,567	28,256	126,311
19	PROFESSIONAL SERVICES	586,670	417,829	168,841	890	863	27
20	FEES, SUBSCRIPTIONS, PROM.	2,549	-	2,549	844	235	609
21	GENERAL OFFICE EXPENSE	18,839	-	18,839	919	-	919
22	EMPLOYMENT BENEFITS & TX.	130,481	10,224	120,257	35,065	6,410	28,655
24	TRAVEL AND SEMINARS	3,121	3,121	-	2,032	2,032	-
25	OTHER STAFF TRANSPORT.	5,252	-	5,252	4,400	-	4,400
26	INSURANCE	-	-	-	-	-	-
34	RENT-FACILITIES & GROUND	59,136	59,136	-	9,792	9,792	-
35	RENTAL EQUIPMENT	301		301	-	-	-
	TOTAL	1,400,890	537,020	863,870	208,509	47,588	160,921

		LIFELINK MATERIALS HANDLING (110)			LIFELINK HUMAN RESOURCES (120)		
LINE #	DESCRIPTION	TOTAL	DIS-ALLOWED	ALLOWED	TOTAL	DIS-ALLOWED	ALLOWED
2	FOOD PURCHASES	-	-	-	50	50	-
17	ADMINISTRATIVE	67,095	-	67,095	110,534	-	110,534
19	PROFESSIONAL SERVICES	4,131	-	4,131	22,307	75	22,232
20	FEES, SUBSCRIPTIONS, PROM.	434	-	434	282	-	282
21	GENERAL OFFICE EXPENSE	2,591	-	2,591	12,081	3,170	8,911
22	EMPLOYMENT BENEFITS & TX.	23,900	-	23,900	15,454	-	15,454
24	TRAVEL AND SEMINARS	-	-	-	-	-	-
25	OTHER STAFF TRANSPORT.	68	-	68	-	-	-
26	INSURANCE	-	-	-	-	-	-
34	RENT-FACILITIES & GROUND	828	828	-	23,112	23,112	-
35	RENTAL EQUIPMENT	59	-	59	-	-	-
	TOTAL	99,106	828	98,278	183,820	26,407	157,413

		BHS G&A BOARD & CORPORATE (010-020)			GRAND TOTAL		
LINE #	DESCRIPTION	TOTAL	DIS-ALLOWED	ALLOWED	TOTAL	DIS-ALLOWED	ALLOWED
2	FOOD PURCHASES	-	-	-	825	825	-
17	ADMINISTRATIVE	-	-	-	1,538,478	366,289	1,172,189
19	PROFESSIONAL SERVICES	71,036	20	71,016	842,608	566,422	276,186
20	FEES, SUBSCRIPTIONS, PROM.	-	-	-	5,869	422	5,447
21	GENERAL OFFICE EXPENSE	12,634	-	12,634	62,664	3,170	59,494
22	EMPLOYMENT BENEFITS & TX.	-	-	-	310,246	66,814	243,432
24	TRAVEL AND SEMINARS	-	-	-	19,336	12,808	6,528
25	OTHER STAFF TRANSPORT.	-	-	-	27,275	-	27,275
26	INSURANCE	1,756	1,756	-	3,978	3,978	-
34	RENT-FACILITIES & GROUND	-	-	-	124,932	124,932	-
35	RENTAL EQUIPMENT	-	-	-	836	-	836
	TOTAL	85,426	1,776	83,650	2,937,047	1,145,660	1,791,387